THERAPEUTIC RADIOLOGIC TECHNOLOGY SCHOOL APPLICATION

1. IDENTIFICATION

a. Name of school or sponsoring institution

b. Address (number/street)	City	County	ZIP code

c. Administrative Head	Title	d. Telephone Number ( )	Ext.

e. Director of the course of study	Title

f. Indicate qualifications:

❒ Radiologist Certified by the ABR ❒ Certified Radiologic Technologist ❒ Radiologic Physicist Certified by the ABR
❒ Other (explain): _____

2. CURRICULUM

a. Is your school's curriculum in writing?

❒ Yes ❒ No

If copy not attached, please explain:

b. Total length of training:

_____ Months

c. Indicate total hours of training in the following areas:

_____ Formal classroom instruction
_____ Radiation protection
_____ Seminars, discussions, demonstrations
_____ Supervised clinical education

Laboratories: _____ General radiographic
_____ Physics and radiation protection
_____ Radiotherapy
_____ Other (specify): _____

3. ORGANIZATION

a. Indicate type of school:

❒ Public community or junior college
❒ Hospital
❒ Other (explain): _____

b. Indicate teaching time:

❒ Day school only
❒ Evening school only
❒ Both day and evening school
❒ Other (explain): _____
❒ Quarter system
❒ Semester system
❒ Continuous

c. School year:

Starting month: _____ Graduation month: _____

d. Accreditation:

(1) Is your school accredited by the AMA Council on Medical Education? ❒ Yes ❒ No
(2) Type and length of approval:
_____

e. Affiliation—Name(s) of affiliated hospital(s) or college(s):

NOTE: Please complete Clinical Training Facilities form for each affiliated hospital.

3. ORGANIZATION *Continued*

f. Indicate degree or certificate granted:

g. Does your school have an active advisory committee?

❒ Yes ❒ No If yes, attach list of members.

4. RECORDS

a. Are all administrative policies clearly stated in writing and maintained in the administrative records?

❒ Yes ❒ No

b. Do you keep records of the following?

	Yes	No
(1) Agreements with other schools, agencies, organizations.	❒	❒
(2) All correspondence with the State Department of Health Services.	❒	❒
(3) Course outlines of all radiologic technology courses.	❒	❒

c. State your school's policy in keeping and issuing transcripts:

d. State your school's admission policy:

	Yes	No
(1) High school diploma required.	❒	❒
(2) Acceptance by admissions committee only.	❒	❒

(3) Other requirements: _____

e. Are all records of individual students maintained showing the following:

	Yes	No		Yes	No
(1) Attendance	❒	❒	(3) Teachers' observations	❒	❒
(2) Grades	❒	❒	(4) Clinical experience record	❒	❒

f. Student Progress Evaluation:

	Yes	No
(1) Is progress of each student evaluated at the end of teaching unit?	❒	❒
(2) Is evaluation done at midterm?	❒	❒
(3) Does the evaluation consist of a written examination?	❒	❒

(4) List other forms of evaluations:

(5) Do you keep copies of the content of all final examinations? ❒ Yes ❒ No

g. Radiation Protection

Are you in compliance with state regulations regarding radiation protection? ❒ Yes ❒ No

h. Radiation protection officer's name and title:

5. FACULTY

a. List names and academic titles of all instructors teaching radiologic technology or subjects related to radiologic technology:

Name	Degree	Title	Radiologic Technologist Certificate Number

5. FACULTY *Continued*

b. Do you keep the following records on each teacher:

	Yes	No
(1) Workload by subject	❒	❒
(2) Hours taught	❒	❒
(3) Percent of full-time teaching	❒	❒
(4) Percent devoted to administrative duties	❒	❒
(5) Subjects taught in the past	❒	❒

6. FACILITIES

a. Describe rooms used for radiologic technology training (number, sizes, and use):

_____

_____

_____

b. Classroom Equipment:

	Yes	No
(1) Are classrooms equipped with a chalkboard (blackboard)?	❒	❒
(2) Are enough seats provided for all students in all classrooms?	❒	❒

c. Describe teletherapy equipment your school possesses or uses for training:

(1) _____

(2) _____

(3) _____

(4) _____

d. Describe film processing equipment:

_____

_____

e. Describe facilities used for laboratory demonstration and practice:

_____

_____

f. Describe phantoms available:

_____

_____

6. FACILITIES *Continued*

g. List audiovisual aids available:

_____

_____

h. Reference Library—Does the reference library contain the following:

	Yes	No
(1) Up-to-date standard textbooks and reference materials on therapeutic radiologic technology	❒	❒
(2) Periodicals on therapeutic radiologic technology	❒	❒

7. ENROLLMENT

a. Number of students in the following categories:

(1) _____ **Total**
(2) _____ Day classes only
(3) _____ Evening classes only
(4) _____ Day and evening classes
(5) _____ Expected to graduate each year
(6) _____ Students the program could accept each year (maximum)
(7) _____ Applications for admission received per month (estimate)
(8) _____ Students your school can accommodate at any one time (maximum)
(9) _____ Applications for admission received in previous year

8. SUPPLEMENTS

a. Please append to this application one copy of the following:

	Appended	Not Appended
(1) School catalog or bulletin	☐	☐
(2) Blank application form for admission	☐	☐
(3) Graduation certificate marked “Copy”	☐	☐
(4) Forms used for records and evaluations	☐	☐
(5) List of course textbooks, references, and periodicals	☐	☐
(6) Joint review committee accreditation	☐	☐
(7) Course descriptions, curricula, and study plans	☐	☐
(8) All affiliation agreements, properly signed	☐	☐
(9) Radiation protection course outline	☐	☐
(10) Advisory committee—composition and function	☐	☐
(11) Transfer credit policies	☐	☐

9. OATH

Name of person completing this form:

_____

I certify that to the best of my knowledge and understanding the foregoing is true and accurate, and that:

☐ The school meets the standards stipulated by *California Laws Relating to Radiologic Technology*, and the implementing regulations.

☐ The school will meet all the standards stipulated by *California Laws Relating to Radiologic Technology*, and the implementing regulations by

_____.
(Date)

➤ _____ _____ _____
Signature of administrative head or director of school | Title | Date signed

Please mail completed form to:

Certification Unit
California Department of Health Services
Radiologic Health Branch, MS 7610
P.O. Box 997414
Sacramento, CA 95899-7414

For additional information, go to www.dhs.ca.gov/rhb or phone (916) 327-5106.